Introduction

The 2003 read me file is designed to help you learn about the data provided on the CD. The data was derived from The Health Care Information System (HCIS), which contains Medicare Part A (Inpatient, SNF, HHA (Part A & B) and Hospice) and Medicare Part B (outpatient) based on the type and State of the institutional provider. Data in HCIS is summarized from the Standard Analytical Files (SAF).

The data sets have been provided in Excel spreadsheet for your convenience. The data set names correspond with the provider type. Brief descriptions of the provider types and the selected reporting elements are provided in the readme file (see Types of Providers and Descriptions of Reporting Elements below).

What is Medicare Part A?

Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

What is Medicare Part B?

Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.

What is a Provider?

A Medicare Provider is an institutional facility, supplier, physician, or other individual/organization that furnishes health care services.

What Types of Providers are Included on this CD?

Home Health Agency (HHA)

An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Hospice

Hospice care is provided for terminally ill patients and their families. It includes physical care as well as counseling services and is covered under Medicare Part A (hospital insurance).

Inpatient

Health care that you get when you are admitted to a short stay or long stay hospital.

Prospective Payment System (PPS)

The PPS system is used by Medicare to pay for most inpatient charges.

Non-PPS

Some providers are excluded from PPS as they are sole community hospitals or rural hospitals.

Outpatient

A service you get in one day (24 hours) at a hospital outpatient department or community mental health center.

Skilled Nursing Facility

A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.

SNF Swing Bed

Hospital beds that can be used when patients no longer need acute care, but still need nursing care and observation. These are units within a short stay hospital.

Non-Swing Bed

These are freestanding facilities.

Descriptions of Reporting Elements (varies by provider type)

Discharge

A formal release from a hospital or SNF.

Provider Address

The primary address of the provider of services.

Provider Name

The name of a facility or other organization that furnishes health care services.

Provider Number

The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

Provider Number Range Code

Developed for HCIS to group like provider types for ease of analysis.

Provider Number Range Description

Developed for HCIS to provide descriptions of the grouped provider types for analysis.

Provider State Code

The two digit SSA State code where the provider facility is located.

State Abbreviation

The two letter abbreviation associated with the State.

Total Claim Payment Amount

The total Medicare payments associated with the specified claim.

Total Days

Medicare covered and non-covered days of care.

Total Payment Plus Passthrough

Medicare payment plus the facility per diem.

Total Patients

Total patients counts by provider type arrayed by State. The columns cannot be summed since the numbers are unique to their element.

Total Utilization Days

The number of days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days.

Total Visits

Frequency of visits by type of service.

HCIS Data Limitations

- HCIS summaries are by Calendar Year unless otherwise specified.
- Privacy: The physician summary data and views (forms) available in HCIS contain identifiers and are protected under The Privacy Act. Release of these data and/or information is prohibited to individuals and/or organizations not granted direct access to this system. In addition, tables containing total reimbursements by individual physicians are not to be released to any external individuals or organizations. Only CMS employees and CMS carriers and Fiscal Intermediaries can have access to this information. There is currently and injunction prohibiting the release of total reimbursement by individual physician.
- Differences in dollar amounts may occur between HCIS and other CMS Part B Systems because of rounding techniques. HCIS rounds at the claim level and BESS, for example, rounds in the last step of the summary process, thereby producing dollar amount differences.
- During the claims summarization process a question mark is inserted into every 'key' or 'sort' field that contained missing or invalid data. Some examples of invalid values are: a UPIN file that was something other than the one alpha and the five numerics; a diagnosis code that included #, %, @. The choices were to convert these missing or invalid values to something that made it clear that the claim was inaccurate, summarize on the invalid, value, or drop the record. Since these claims were paid, the decision to indicate the data anomaly with a question mark. The question mark was chosen because it comes to the top in an ASCII sort, and it means "unknown." In every case, drilling down on a questions mark will yield a summary line for every question mark in that field.
- Ownership information is being updated. We will incorporate the updated file as soon as it becomes available.
- If the claim payment amount is less than 0.001 it is moved to the Claims excluded file. This takes care of)'s and negative numbers.
- HHA data in HCIS reflects all HHA payments under the Total Payments field (including RAPs, LUPAs, etc.) Please be aware of this when reviewing the information presented on the screens. These screens are being reviewed for the impact of PPS. Required modifications will be incorporated via change control and reflected in a future version of the HCISmod application (newer/modernized version of this HCIS "legacy" application).
- When PPS was implemented in October 2000, Medicare claims started coming in as "1 claim per episode" of care. Prior to PPS, Medicare received multiple claims per HHA 'episode of care.' For this reason, there is a noticable drop in the # of claims following the implementation of PPS. Since PPS only accounted for 1 quarter of 2000 data, the drop in claim count is most noticable with the 2001 data.
- Forms that show provider numbers along with their associated provider range code (the two left-most columns) do not offer the trending option. This was

deliberate as the trending function does not accommodate the special circumstances presented by the dual-key nature of the provider number/range code combination.